STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES
BUREAU FOR MEDICAL SERVICES

Office of Pharmacy Service
Prior Authorization Criteria

Invokana® (canagliflozin)

Prior Authorization Request Form

Prior authorization requests for Invokana will be approved for six (6) months if the following criteria are met:

1. Diagnosis of Type 2 Diabetes; **AND**
2. Thirty (30) day trial of metformin or metformin combination, and at least one (1) other first line oral agent (e.g. TZD or sulfonylurea) within the past six (6) months; **AND**
3. Patient must have $HgBA^1C$ levels equal to or less than 10.5%; **AND**
4. Patient must have glomerular filtration rate equal to or greater than $45ml/min/1.73m^2$; **AND**
5. Prior authorizations will be issued at six (6) month intervals if $HgBA^1C$ levels are equal to or less than 8%.
   (Laboratory work submitted must be for the most recent thirty (30) day period)

Jannsen Pharmaceuticals, Inc.
Titusville, NJ 08560 March 2013

Am J Health System Pharm
2013;70:311-19

Reviewed and Approved
Drug Utilization Review Board
September 18, 2013
May 21, 2014